JAISOHN Medical Center

Pre Vaccination Checklist / Consent Form for the COVID-19 Vaccine

Section I: Patient Information

Name:_____ DOB: _____ Phone #: _____

Email Address: _____Gender: (M)___ (F) ____

Address: _____

Insurance Name: _____ Insurance Member ID: _____

Moderna Vaccine: (1st) _____ (2nd) _____ Pfizer Vaccine: (1st) _____ (2nd) _____ Janssen Vaccine: _____

Section II: Screening Questions

	YES	NO
1. Are you feeling sick today?	_____	_____
2. Have you ever had an allergic reaction to:		
(a) Covid-19 vaccine component including		
• Polyethylene glycol/PEG (found in some medication, such as laxatives and preparations for colonoscopy procedures)	_____	_____
• Polysorbate (emulsifying agent, found in some vaccines, film coated tablets and intravenous steroid)	_____	_____
(b) Previous covid-19 vaccine	_____	_____
3. Have you ever had an allergic reaction to another vaccine or injectable medication?	_____	_____
4. Have you ever had a severe allergic reaction (anaphylaxis) to something other than those mentioned above (food, pet, environmental, medications, etc.)	_____	_____
5. In the **last 14 days**, have you received any vaccine?	_____	_____
6. Have you been tested positive for Covid-19?	_____	_____
• If yes, did you receive passive antibody therapy (monoclonal antibody or Convalescent serum) treatment? If so, when: _____	_____	_____
7. Do you have a weakened immune system caused by something such as an HIV infection or cancer or do you take any immunosuppressive drugs?	_____	_____
8. Do you have a bleeding disorder or are you taking a blood thinner?	_____	_____
9. **FOR WOMEN ONLY**: Are you pregnant or breastfeeding?	_____	_____
10. Do you have any dermal fillers?	_____	_____

Section III: Consent

- The information about the COVID-19 vaccine has been explained to me. I understand the FDA has **authorized the emergency use of the COVID-19 vaccine,** which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.
- I understand the significant known potential risks and benefits of the COVID-19 vaccine as explained to me and that some potential risks and benefits may remain unknown, but **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**
- I agree to stay in the vaccine administration area for 15 minutes (or longer if indicated by the staff) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

Sign HERE: _____ **Date:** _____

Section IV: Vaccination Record FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date of Administration	Vaccine Manufacturer	Lot #	Expiration Date	Name of Vaccine Administrator
Covid		I M					